MONTANA CHIP Rx FORM

PATIENT INFORMATION AND Rx

Patient Name ☐ *Mail to Patient*	Birth Date	Exam Date	Invoice Number
	/ /		
Address Street	PIC Number	ICD-9DX Code	Order Date
City State Zip	CHIP ID No.	Date Received	Date Shipped

Sphere	Cylinder	Axis	Prism/Base	Decenter	Distant PD	Near PD
R						
L						

Add	Near Inset	Total Inset	Seg. Height	OC Height	Center Thickness	Edge Thickness	
R							☐
L							

LENS INFORMATION

Material	Lens Style	Seg Style	Base Curve	
☐ *Plastic*	☐ *SV:*		R	
☐ *Glass*	☐ *Bifocal:*		L	
☐ *High Index*	☐ *Trifocal:*		Lens Coating/Lens Tint	
☐ *Polycarbonate*	☐ *Aphakic:*			
☐ *Other*				

SCRATCH COAT: ☐

FRAME INFORMATION

☐ SUPPLY ☐ LENSES ONLY ☐ 2ND PR S.V. ☐ Rx CHANGE

☐ ZYL ☐ METAL ☐ GROOVE ☐ HALF EYE

Frame Name	Color	Eye Size	Bridge	Temple
			☐ AP ☐ FF	☐ SK ☐ CC

Manufacturer	Frame or Pattern #	Frame Measurements			Shape Code	Circumference
		A:	B:	ED:		

NOTE: A copy of the recipient's CHIP ID card must be attached to the Rx order.

Reimbursement By	Provider	State
Lenses		
Frame		
Photo-Chromic		
Tint		
Ultra Violet		
Scratch Coat		

TRAY #	PROVIDER NO.	TOTAL	